920b BEHAVIORALLY CHALLENGING PATIENT ADD-ON

This "add on" which was effective July 1, 2003, was designed to recognize and compensate providers for patients that require an inordinate amount of resources due to the intensive labor involved in their care.

Behaviorally challenging patients are defined as follows:

Behaviorally complex resident means a Long Term Care resident with a severe medically based behavior disorder (including but not limited to Traumatic Brain Injury, Dementia, Alzheimer, Huntington's Chorea) which causes diminished capacity for judgment, retention of information and/or decision making skills, or a resident, who meets the Medicaid criteria for Nursing facility level of care, and who has a medically based mental health disorder or diagnosis and has a high level resource use in the Nursing facility not currently recognized in the case mix system.

To qualify for a behaviorally challenging patient "add on" the provider must document that the patient involved meets the following criteria:

- The resident meets the criteria for Nursing facility level of care as found in the Utah Administrative Rule: Nursing Facility Levels of Care, R414-502,
- The resident has a primary diagnosis which is identified with the appropriate ICD9 code on the MDS as listed:
  - ICD9-331, Alzheimer's Disease,
  - ICD9-290, Dementia Other than Alzheimer's. This can include organic brain syndrome (OBS), chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurological disease other than Alzheimer's (e.g., Picks, Creutzfeld-Jacob, Huntington's disease, etc.),
  - ICD9-854, Traumatic Brain Injury (TBI).
- And, the resident has a history of regular/recurrent persistent disruptive behavior which is not easily altered evidenced by one or more of the following which requires an increased resource use from Nursing facility staff:
  - The resident engages in wandering behavior moving with no rational purpose, seemingly oblivious to their needs or safety,
  - The resident engages in verbally abusive behavioral symptoms where others are threatened, screamed at, cursed at,
  - The resident engages in physically abusive behavioral symptoms where other residents are hit, shoved, scratched, and sexually abused,
  - The resident engages in socially inappropriate/disruptive behavioral symptoms by making disruptive sounds, noises, screaming, self-abusive acts, sexual behavior or disrobing in public, smearing/throwing food/feces, hoarding, rummaging through others belongings,
  - The resident engages in behavior that resists care by resisting medications/ injections, Activities of Daily Living (ADL) assistance, or eating.

And, the Nursing Facility staff shall have established behavior baseline profile of the resident following R414-502-4 (6)(a) through (g) guidelines and implemented a behavior intervention program designed to reduce/control the aberrant behaviors, and a specialized document program that increases staff intervention in an effort to enhance the resident's quality of life, functional and cognitive status.

It should be noted that any MR/DD residents who are receiving the specialized rehabilitation services (SRS) add on rate will be excluded from receiving this add on rate.

Facilities that document patients that have behaviorally challenging problems as defined above will be paid an "add-on" rate as described in Section 930.

921 RUGs NURSING COMPONENT

The Resource Utilization Groups (RUGs) is a severity-based payment system. A facility case mix system is employed in the computation of the RUGs component of the per diem payment rate. Case mix is determined by establishing a RUGs weight for each patient. Available RUGs scores for each patient are combined with the scores of all other patients to establish a composite weight for all patients in the facility. The composite weight is multiplied by a dollar conversion factor to arrive at a per diem amount for the facility payment rate. The "dollar conversion factor" is defined as the rate established yearly by the state that is determined as a result of consideration of the average case mix changes and the necessary resources to maintain proper care levels for the patients. For all practical purposes this is a rate which, having been established in the initial year commencing January 1, 2003, will be updated to recognize proper increases necessitated by normal cost increases. The "dollar conversion factor" has been adjusted effective July 2, 2004 to take into account 24 months of inflation (6%, as measured by the PPI), inclusion of raw food in the case mix component, and ancillary nursing costs separate from nursing salaries, wages and benefits formerly paid as part of the flat rate. The Rugs component of the rate has been rebased at the 96th percentile of historical costs as explained in Section 920. The results of these changes are reflected in the increased case mix component included in this section.

The per patient day base rate, on average, for all facilities is composed of the three components; property component, case mix component and the flat rate component, is outlined as follows:

Component Amounts for July 2, 2004

Property component:	$14.80
Case Mix Component:	$76.60
Flat Rate Component:	$40.40
Total Average Rate:	$131.80

Rates are to be effective July 2 instead of July 1 due to state Administrative rule-making time frames.

900 RATE SETTING FOR NFs (Continued)

In addition to the base rate, the following add-on payments will be applied to qualifying facility payment rates in the proportion that the facility qualifies for the add-on factor;

Quality Incentive	$0.43
Hold Harmless (property)	$0.78
SRS	$0.78
Behavioral Complex	$1.63
Swing beds	$0.43
Total Add-on	$4.05

Example: a rate determination of facility A-1 Care (hypothetical) which had a case mix or severity index of 0.9562 and a qualified property amount of $14.80 is as follows:

Property Payment ppd.:	$14.80
Case Mix Component:	
Index x Case Mix Component ppd:	
Or 0.9562 x $78.40 =	$74.97
Flat Rate Component ppd:	$38.60
Total Rate	$128.37

Please note that urban / rural adjustment was not considered in this example as this was presented to demonstrate the use of a case mix adjustment on the rate only.

The facility case mix will be calculated quarterly resulting in quarterly rate setting.

922 FLAT RATE NON-NURSING COMPONENT

The flat rate is a fixed amount paid for all Medicaid patients and reflects the proportion of the overall nursing home rate that is considered to not be variable in nature. The flat rate category is increased periodically for inflation. The flat rate component includes: (1) general and administrative, (2) plant operation and maintenance, (3) dietary (except raw food) including dietary supplements), (4) laundry and linen, (5) housekeeping, and (6) recreational activities. Effective July 2, 2004, the flat rate component amount is $40.40 per patient day..

923 PROPERTY (BASE AND DIFFERENTIAL)

For the Fiscal year beginning July 1, 2004 until September 15, 2004, (see Section 634) all patient per diem rates includes $11.19 in the flat rate component based on historical property payments. Some providers receive a property differential in their per diem rate. The property differential is the amount between $11.19 and the $20.00 ceiling. While many of the nursing facilities will not qualify because their property costs are below $11.20, others will receive between $.01 and $8.81 per day based on allowed property costs reported on the FCP above $11.19 per day. The $11.19 per day was based on $8.66 in the FY 1995 rates inflated to $11.19 for FY 2005 rates.

In determining the amount of the property differential, the calculated cost per day is reduced when occupancy is below 75%. Property cost allowed on the 2001 FCP is divided by the greater of 1) reported patient days or 2) licensed beds times 365 days times 75%.

924 NEW FACILITIES

Newly constructed facilities are paid the average per diem base rate. This average rate will be paid for up to six months at which time, the provider's case mix index will be established. A new prospective rate will be paid. Thereafter the property payment to the facility will be controlled by R414-504-3(5). Prior to implementation of a fair rental value system, a newly constructed facility's property payment may not exceed $20.00 per patient day.

An existing facility acquired by a new owner will continue with the same per diem payment rate (same case mix index and property component established for the previous ownership. Prior to implementation of a fair rental value system, the new owners property payment may not exceed $20.00 per patient day

ATTACHMENT 4.19-D

900 RATE SETTING FOR NFs (Continued)

(h) The Department may withhold or deny payment of the interim or other adjustment if the facility fails to obtain the required agreement prior to the scheduled effective date of the adjustment.

(i) The additional payment provided to a facility as a result of this provision may not exceed the reasonable and documented cost of providing the services involved. Additionally, the additional payment may not be less than the cost of providing at a minimum the "variable" or incremental cost involved in providing the service.

926 UNDER-SERVED AREAS

When the Medicaid agency determines that a facility is located in an under-served area, or addresses an under-served need, the Medicaid agency may negotiate a payment rate that is different from the case mix index established rate. This exception will be awarded only after consideration of historical payment levels and need. The maximum increase will be the lesser of the facility's reasonable costs (as defined in CMS publication 15-1, Section 2102.2) or 7.5% above the average of the most recent Medicaid daily rate for all Medicaid residents in all freestanding nursing facilities in the state. The maximum duration of this adjustment is 12 months. The following guidelines and criteria apply to determination of these special rate adjustments for under-served areas:

(a) A sole community provider that is financially distressed may apply for a payment adjustment above the case mix index established rate.

(b) The application shall propose what the adjustment should be and include a financial review prepared by the facility documenting:
   (I) the facility's income and expenses for the past 12 months; and
   (ii) steps taken by the facility to reduce costs and increase occupancy.

(c) The Department may conduct its own independent financial review of the facility prior to making a decision whether to approve a different payment rate.

(d) If the Department determines that the facility is in imminent peril of closing, it may make an interim rate adjustment for up to 90 days.

(e) The Department's determination shall be based on maintaining access to services on and maintaining economy and efficiency in the Medicaid program.

(f) If the facility desires an adjustment for more than 90 days, it must demonstrate that:
   (i) the facility has taken all reasonable steps to reduce costs, increase revenue and increase occupancy;
   (ii) despite those reasonable steps the facility is currently losing money and forecast to continue losing money; and
   (iii) the amount of the approved adjustment will allow the facility to meet expenses and continue to support the needs of the community it serves, without unduly enriching any party.

(g) If the Department approves an interim or other adjustment, it shall notify the facility when the adjustment is scheduled to take effect and how much contribution is required from the local governing bodies. Payment of the adjustment is contingent on the facility obtaining a fully executed binding agreement with local governing bodies to pay the contribution to the Department.

927 QUALITY IMPROVEMENT INCENTIVE

Funds in the amount of $500,000 shall be set aside annually to reimburse facilities that have a quality improvement plan and have no violations that are at an Immediate jeopardy level, as determined by the Department, at the most recent re-certification survey and during the incentive period. The Department shall distribute incentive payments to qualifying facilities based on the proportionate share of the total Medicaid patient days in qualifying facilities. If a facility appeals the determination of a survey violation, the incentive payment will be withheld pending the final administrative appeal. On appeal, if violations are found not to have occurred at a severity level of Immediate jeopardy or higher, the incentive payment will be paid to the facility. If the survey findings are upheld, the remaining incentive payments will be distributed to all qualifying facilities.

928 URBAN/ NON-URBAN LABOR DIFFERENTIAL

In developing payment rates, the Department will adjust urban and non-urban rates to reflect differences in urban and non-urban labor costs. The urban labor cost reimbursement cannot exceed 106% of the non-urban costs. Labor costs are as reported on the most recent FCPs, but do not include FCP-reported management, consulting, director, and home office fees.

930 BEHAVIORALLY CHALLENGING PATIENT ADD-ON

Behaviorally challenging patients may qualify for a special add-on payment rate. The rate established for the base year of 2002 is considered to be $6.60 per patient day (ppd) and is inflated to $7.00 ppd for FY 2005. This rate was determined after extensive "on site" time studies at providers sites. The study determined that additional time involved by all levels of nursing care for these patients, and applied an average amount per hour. This study will be updated on an "as needed" basis.

931 SPECIALIZED REHABILITATION SERVICES (SRS) FOR INDIVIDUALS

An amount is added to the facility rate that pertains to approved patients. Because the SRS rate is paid in addition of the facility specific rate, the resulting revenue is offset against the nursing costs on the FCP.

(i) The Department may withhold or deny payment of the interim or other adjustment if the facility fails to obtain the required agreement prior to the scheduled effective date of the adjustment.

(iij) The additional payment provided to a facility as a result of this provision may not exceed the reasonable and documented cost of providing the services involved. Additionally, the additional payment may not be less than the cost of providing at a minimum the "variable" or incremental cost involved in providing the service.